



## State Farm Group Medical PPO Plan Option 2T – Retirees Benefits Summary

<b><i>Benefits effective January 1, 2010</i></b>		
<b>Related Internet Sites</b>	<a href="http://www.bcbsil.com/statefarm">www.bcbsil.com/statefarm</a> <a href="http://www.caremark.com">www.caremark.com</a> or <a href="http://www.caremark.com/statefarm">www.caremark.com/statefarm</a> <a href="http://www.SFLiveWell.com">www.SFLiveWell.com</a> (Alere)	
<b>Customer Service Numbers</b>	Group Medical 1-888-652-4013 Caremark 1-800-388-2058 Good Neighbor Healthy Living (Alere) <sup>1</sup> 1-866-549-5088 (toll free)	
<b>Individual Annual Deductible</b>	\$ 1,000	
<b>Family Annual Deductible</b>	\$ 2,000	
<b>Lifetime Maximum Aggregate Benefit Per Individual</b>	The maximum lifetime benefit per individual is \$2,000,000.  The net cost of prescription drugs (the amount State Farm pays) will be applied towards the individual lifetime maximum of \$2,000,000.	
	<b><i>PPO Provider</i></b>	<b><i>Non-PPO Provider</i></b>
<b>Individual Annual Out-of-Pocket Expense Limit (includes the Annual Deductible)<sup>2</sup></b>	\$3,000	\$5,000
<b>Family Annual Out-of-Pocket Expense Limit (includes the Annual Deductible)<sup>2</sup></b>	\$6,000	\$10,000
<b>Coinsurance Percentage</b>	After the satisfaction of the deductible, <b>10%</b> coinsurance required for charges from PPO Providers until the annual Out-of-Pocket Expense Limit is reached. Eligible charges <b>are not</b> subject to U&C limitations.	After the satisfaction of the deductible, <b>40%</b> coinsurance required for charges from Non-PPO Providers until the annual Out-of-Pocket Expense Limit is reached. Eligible charges <b>are</b> subject to U&C limitations.
<b>Physician Services</b>	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and <b>40% Non-PPO Provider</b> coinsurance.
<b>Inpatient Hospitalization<sup>3</sup></b>	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and <b>40% Non-PPO Provider</b> coinsurance.
<b>Emergency Care</b>  For each Visit to an Emergency Room, the member will be responsible for the first \$100 in Eligible Charges.	After the application of the Emergency Room Visit Charge, remaining eligible charges subject to deductible and 10% PPO Provider coinsurance.	After the application of the Emergency Room Visit Charge, remaining eligible charges subject to deductible, U&C and <b>10% PPO Provider</b> coinsurance.
<b>Ambulance</b>	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible and <b>10%</b> coinsurance of billed charges.
<b>Maternity Care: Pre-/Post-Natal Office Visit</b>	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and <b>40% Non-PPO Provider</b> coinsurance.
<b>Maternity Care: Inpatient Delivery<sup>3</sup></b>	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and <b>40% Non-PPO Provider</b> coinsurance.

<b>Well Child Care (Not subject to annual deductible)</b>  Sports and employment physicals are not eligible.	100% coverage for regularly scheduled checkups, immunizations, screening lab tests, and other associated diagnostic services from birth through age 16.	<b>60%</b> coverage subject to U&C allowance for regularly scheduled checkups, immunizations, screening lab tests, and other associated diagnostic services from birth through age 16.
<b>Preventive Care – adults age 17 or older (Not subject to annual deductible)</b>	100% coverage for preventive diagnostic tests and services not provided under the Cancer Prevention Screenings. Benefits are limited to <b>\$1000</b> per individual per year.	<b>60%</b> coverage subject to U&C allowance for preventive diagnostic tests and services not provided under the Cancer Prevention Screenings. Benefits are limited to <b>\$1000</b> per individual per year.
<b>Cancer Prevention Screenings (Not subject to annual deductible and does not apply towards the \$1000 Preventive Care benefit listed above)</b>	100% coverage for preventive cancer screenings for breast, colorectal, cervical and prostate cancer. Eligible screening intervals may vary.	<b>60%</b> coverage subject to U&C allowance for preventive cancer screenings for breast, colorectal, cervical and prostate cancer. Eligible screening intervals may vary.
<b>Mental Health and Substance Abuse</b>	Eligible charges subject to deductible and 10% PPO Provider coinsurance. <b>Treated as any other illness.</b>	Eligible charges subject to deductible, U&C and <b>40% Non-PPO Provider</b> coinsurance. <b>Treated as any other illness.</b>
<b>Physical, Occupational and Speech Therapy Coverage</b>	Eligible charges subject to deductible and 10% PPO Provider coinsurance with the following calendar year maximums per covered individual: Physical Therapy - \$2500 Occupational Therapy - \$1000 Speech Therapy - \$1000	Eligible charges subject to deductible, U&C and <b>40% Non-PPO Provider</b> coinsurance with the following calendar year maximums per covered individual: Physical Therapy - \$2500 Occupational Therapy - \$1000 Speech Therapy - \$1000
<b>Organ Transplants <sup>4</sup></b>	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and <b>40% Non-PPO Provider</b> coinsurance.
<b>Durable Medical Equipment</b>	Eligible charges subject to deductible and 10% PPO Provider coinsurance.	Eligible charges subject to deductible, U&C and <b>40% Non-PPO Provider</b> coinsurance.
<b>Contraceptive Coverage</b>	Oral contraceptives are covered under the Outpatient Prescription Drug Benefit; FDA approved prescription devices, procedures, and supplies and corresponding office visits subject to deductible and 10% PPO Provider coinsurance.	Oral contraceptives are covered under the Outpatient Prescription Drug Benefit; FDA approved prescription devices, procedures, and supplies and corresponding office visits subject to deductible, U&C and <b>40% Non-PPO Provider</b> coinsurance.
<b>Prescription Drug Coverage</b>	<b>Prescription Drug Coinsurance amounts do not apply toward the Out-of-Pocket Expense Limits.</b>	
<b>Retail</b> • Generic  • Preferred Brand-Name  • Non-Preferred Brand-Name	<b>Maximum 30-Day Supply</b> • <b>20% coinsurance for generics with a \$10 minimum and \$25 maximum</b> • <b>30% coinsurance for medications included on the Preferred Drug List with a \$10 minimum and \$50 maximum</b> • <b>50% coinsurance with a \$10 minimum and a \$75 maximum for medications not included on the Preferred Drug List</b>	
<b>Mail Order or retail CVS/pharmacy</b> • Generic  • Preferred Brand-Name  • Non-Preferred Brand-Name	<b>Maximum 90-Day Supply</b> • <b>20% coinsurance for generics with a \$20 minimum and \$50 maximum</b> • <b>30% coinsurance for medications included on the Preferred Drug List with a \$20 minimum and \$100 maximum</b> • <b>50% coinsurance with a \$20 minimum and a \$150 maximum for brand name medications not included on the Preferred Drug List</b>	
<b>Maintenance Medications at Retail</b>	A maintenance medication can be filled at a retail pharmacy three times during the calendar year (maximum 30-day supply), however, for the 4 <sup>th</sup> and subsequent fills, you will receive each 30-day supply at the mail order cost. This does not apply to maintenance medications purchased at a retail CVS/pharmacy.	

<p><b>CVS Caremark Value Generic Program for Maintenance Medications</b></p> <p>To obtain a current Value Generic Drug List log in to <a href="http://www.Caremark.com">www.Caremark.com</a> or contact CVS Caremark at 1-800-388-2058.</p>	<p>Certain generic maintenance medications (maximum 90-day supply) can be purchased at a retail CVS/pharmacy or through mail order at a cost of \$9.99* in most states. The coinsurance percentage or the minimum and maximum amounts do not apply to Value Generic medications purchased at a retail CVS/pharmacy or via mail order.</p> <p>The Value Generic Program does not apply to generic maintenance medications purchased at non-CVS retail pharmacies. *These drugs may be priced higher in CA, HI, MN, MT, PA, TN, WI, and WY due to state legislation. These medications are noted in the Value Generic Drug List and are consistent with other pharmacies operating in these states.</p>
<p><b>Quantity Limitations</b></p>	<p>All drugs prescribed for the treatment of erectile dysfunction will be limited to 8 pills per 30-day supply and 24 pills per 90-day supply.</p>
<p><b>Diabetic Supplies</b></p>	<p>Insulin, insulin syringes, lancets, lancing devices and glucagon emergency kits are eligible under the Outpatient Prescription Drug Expense Benefit through Caremark. A separate prescription is required for each item and each prescription will be subject to the applicable coinsurance.</p> <p>Test strips for glucose monitors will be provided free of charge when purchased at a Caremark participating pharmacy or through Caremark's Mail Order Pharmacy.</p> <p>Alcohol wipes and cotton balls are not eligible under the Plan.</p>

**Disclaimer:** This summary does not create a contract or binding agreement. This information is provided in summary for ease of comparison only. In the event there is a discrepancy between the information presented here and the actual plan document, the plan document or contract will prevail.

<sup>1</sup> Good Neighbor Healthy Living is a program available under the Group Medical PPO plan designed to help covered individuals better understand and manage certain chronic health conditions through the use of health coaches and other tools and resources. In addition, Good Neighbor Healthy Living provides a variety of on-line healthy living programs to promote healthier lifestyles among covered associates and their eligible dependents.

<sup>2</sup> Eligible Charges incurred by PPO Providers will be used toward satisfying the Non-PPO Provider Out-of-Pocket Expense Limits up to the PPO Provider Out-of-Pocket Expense Limits and Eligible Charges incurred by Non-PPO Providers will be used to satisfy the PPO Provider Out-of-Pocket Expense Limits up to the PPO Provider Out-of-Pocket Expense Limits.

<sup>3</sup> An additional **\$100** Pre-Admission Utilization Review Charge (per hospitalization) is applied if the Blue Cross Blue Shield Medical Services Advisor is not contacted within one business day prior to a scheduled hospital admission or within two business days of an emergency admission, maternity care, mental health or chemical dependency admission.

<sup>4</sup> For transplants performed at a Blue Distinction Centers for Transplants, after the applicable annual deductible is satisfied, benefits will be increased 10% (not to exceed 100%) for the global fee for the transplant. For other benefits associated with this program, contact the Group Medical Customer Service Unit.